

39 Patient 1st

The **Patient 1st** Manual has been developed by the Alabama Medicaid Agency to explain the policies and procedures of the Patient 1st program. Every effort has been made to present qualified providers a comprehensive guide to basic information concerning program requirements and billing procedures. The policies outlined in this manual are binding upon the provider. Providers should also refer to the EDS Provider Insider regarding any updates or changes within this program.

If you have any questions about this program please contact the Provider Assistance Center at 1-800-688-7989.

39.1 Overview

Patient 1st is Medicaid's primary care case management (PCCM) program, linking Medicaid recipients with a primary medical provider (PMP). The PMP acts as a gatekeeper to provide and arrange for most of the recipient's health care needs. PMPs bill fee-for-service and are reimbursed based on the Medicaid fee schedule. PMPs also receive a monthly case management fee per member, per month for coordinating the care of Medicaid recipients enrolled with their practice. The goal of this managed care program is to improve health care for Medicaid recipients by providing a "medical home" while containing the escalating cost of providing quality healthcare.

Patient 1st operates pursuant to an approved 1915(b) (1) waiver granted in accordance with Title XIX of the Social Security Act. The program was operational from 1997 through February 29, 2004. The Program was re-instated effective December 1, 2004. **Patient 1st** was active in all counties effective February 1, 2005. Providers can access Medicaid's website for details on the implementation schedule at www.medicaid.state.al.us.

Patient 1st can be successful only with the commitment of the provider community. To ensure an adequate provider base, the Alabama Medicaid Agency (Medicaid) executes provider agreements with physicians on a continuous basis who wish to participate in the **Patient 1st** Program. The physician acting as a PMP agrees to abide by all existing laws, regulations and procedures pursuant to the **Patient 1st** Program and Medicaid participation.

39.2 Eligible Providers

39.2.1 Enrollment

Alabama Medicaid providers who are interested in participating as a Patient 1st provider must complete and submit a **Patient 1st Application Package** (application and agreement) to the EDS Provider Enrollment Unit. A copy of the application package is available on Medicaid's website at www.medicaid.state.al.us or by calling the Provider Assistance Center at 1-800-688-7989.

The following provider types are eligible to participate as a PMP for the Patient 1st Program:

- Family Practitioners
- General Practitioners
- Pediatricians
- Internists
- OB/GYN
- Federally Qualified Health Centers
- Rural Health Clinics

NOTE:

When in the best interest of a patient, a nontraditional PMP may be chosen (e.g., children with special health care needs). Other physicians may be considered for PMP participation if willing to meet all contractual requirements.

A participating physician in a clinic or health center can not work at more than three sites and must provide Medicaid with information regarding percentages of time spent at each site and the number of Patient 1st enrollees per site.

The Patient 1st enrollee must be given information regarding the usual days and hours the physician is available for scheduled appointments. If a certified nurse practitioner or physician assistant cares for an enrollee, the enrollee must know the Patient 1st physician responsible for supervision. These obligations can be fulfilled through office signs, verbal instructions or written information.

The PMP has the option of being placed on the published or non-published PMP list. The PMP must indicate their preference when completing the Patient 1st Enrollment Form. The PMP list includes the PMP's county (ies) of participation, the PMP's name, specialty, physician extenders, physical address, and phone numbers (regular and 24 hour). This PMP list is sent to all Medicaid recipients to assist them in selecting physicians/clinics serving their county. The PMP list may also be accessed via the Medicaid web site at www.medicaid.state.al.us.

Regardless of publication, the PMP is included in the assignment process if caseload is available and criteria can be met.

39.2.2 Caseload

The following standards apply to PMP caseloads:

PMPs may serve multiple counties and/or sites; however, the maximum panel a PMP can serve collectively is 1200, with the minimum of 25. PMPs may specify the number of **Patient 1st** enrollees they will accept per county and/or site.

Physician Extenders (Nurse Practitioners and Physician Assistants) will allow the caseload to be extended by 400 additional patients per extender. Only two Physician Extenders per physician will be allowed and may only be counted once in a caseload extension.

The PMPs practice must be opened a minimum of 32 hours per week and the PMP must practice at that location a minimum of 32 hours per week to be considered a Full Time Equivalent (FTE).

If less than an FTE, a percentage of a total patient caseload will be allowed, based on availability.

Caseloads for group/clinic enrolled providers will be determined by the number of FTEs and physician extenders associated with the group.

NOTE:

If a nontraditional PMP has been assigned based on a case need, the minimum enrollee or full time requirement will not apply.

If the PMP wishes to extend the caseload above 1200 or 2000 (with extenders), a written request from the PMP for an extension of the PMP enrollee cap should be submitted in writing and must address the following:

The PMP's name and Medicaid number;

The total number of enrollees over the cap that the PMP is requesting;

The reason for the request to extend the PMP enrollee cap;

The total number of patients the PMP is seeing who are not Medicaid (PMP may provide the actual total of patients broken down by payer source, and/or PMP's percentage of Medicaid enrollees to total patients and/or the percentage of Medicaid income to total income);

The length of time the PMP has been in practice in the area;

Description of PMP's practice, such as, is the PMP in private or group practice;

Other extenuating documentation and explanations that would justify the request for an extension of the cap.

The request can be submitted at the time the Provider Agreement is signed or at a later date by contacting EDS Provider Enrollment.

**** A PMP's caseload may be exceeded to accommodate sibling assignment, newborn assignment, or assignments for previously established patients (last PMP on file).**

If the PMP wishes to decrease the number of enrollees, he/she must notify EDS Provider Enrollment in writing, at least thirty (30) days in advance of the planned decrease in enrollees to allow for enrollee reassignment. If the PMP wishes to increase the maximum number of enrollees within the caseload specifications, he/she must notify EDS Provider Enrollment in writing. Such changes should be faxed to (334) 215-4298.

Individual or specific recipient additions or dismissals must be made in writing on the requesting provider's letterhead and include the following information; the provider's name and provider number as enrolled in the Patient 1st Program, the recipient's name, Medicaid number and the county in which the recipient lives. These changes can be faxed to the Patient 1st Program at (334) 353-3856.

Any changes made to the PMP's panel should be with the understanding that no individuals eligible to enroll in Patient 1st will be discriminated against on the basis of health status or the need for health care services. Further, the PMP must accept individuals in the order in which they apply without restriction up to the limits set by the PMP and the Agency.

39.2.3 Disenrollment

The PMP's agreement to participate in the Patient 1st program may be terminated by either the PMP or Agency, with cause or by mutual consent; upon at least 30 days written notice and will be effective on the first day of the month, pursuant to processing deadlines. (NOTE: Failure to provide a 30-day notice may preclude future participation opportunities and/or recoupment of case management fees.)

A written request must be submitted by the PMP to Provider Enrollment at EDS with the effective date given. Patients will automatically be reassigned based on the following:

If a PMP is leaving a group practice, then patients will be reassigned to a practitioner within the group; or

If the remaining group practitioner does not want to assume the caseload, then patients will be assigned through the automated assignment process. For a short period of time, these patients will not be enrolled in the **Patient 1st Program**; or

If the PMP has made arrangements with another practitioner to assume his/her caseload, then these specifics will be taken into consideration. The disenrollment notification must specify such arrangements.

39.3 PMP Responsibilities

39.3.1 *Functions and Duties*

The PMP and its group practice/clinic shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the provider agreement is signed, or that come into effect during the term of the agreement. This includes, but is not limited to the approved waiver document and Title 42 of the Code of Federal Regulations.

The Patient 1st PMP agrees to do the following:

Be a licensed physician, enrolled in the Alabama Medicaid Program, who has not been sanctioned.

Accept enrollees and be listed as a PMP in the Patient 1st Directory for the purpose of providing care to enrollees and managing their health care needs through the Medical Home concept.

Provide primary care and patient care coordination services to each enrollee in accordance with the policies set forth in Medicaid provider manuals and Medicaid bulletins and as defined by Patient 1st policy.

Provide or arrange for primary care coordination and coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week as defined by Patient 1st policy. Automatic referral to the hospital emergency department for services does not satisfy this requirement. PMPs must have at least one telephone line that is answered by the office staff during regular office hours.

Provide EPSDT preventive care screenings to Medicaid eligible children age birth through 20. PMPs serving this population who do not provide EPSDT services are required to sign an agreement with another provider to provide EPSDT services. PMPs must retain a copy of this agreement in their files and must ensure that their records include information regarding the extent of these services.

Maintain a unified patient medical record for each enrollee following the medical record documentation guideline as defined by Patient 1st policy.

Promptly arrange referrals for medically necessary health care services that are not provided directly and document referral for specialty care in the medical record. Provide the authorization number (Medicaid provider number) to the referred provider.

Transfer the Patient 1st enrollee's medical record to the receiving provider upon the change of primary medical provider at the request of the new primary care provider and as authorized by the enrollee within 30 days of the date of the request. Note: Patients must request their records be transferred to the new PMP and must not be charged a fee for this service.

Authorize care for the enrollee or see the enrollee based on the standards of appointment availability as defined by Patient 1st policy.

Refer for a second opinion as defined by Patient 1st policy.

Review and use all enrollee utilization and cost reports provided by the Patient 1st program for the purpose of practice level utilization management and advise the Agency of errors, omissions, or discrepancies. Review and use the monthly enrollment report as required by Patient 1st policy.

Participate with Agency utilization management, quality assessment, and administrative programs.

Provide the Agency or its duly authorized representative or the Federal government unlimited access (including on site inspections and review) to all records relating to the provision of services under the provider agreement as required by Medicaid policy and 42 C.F.R. 431.107.

Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines or guidelines approved by the Patient 1st Advisory Group.

Notify the Agency of any and all changes to information provided on the initial application for participation. If such changes are not reported within 30 days of change, then future participation may be limited.

Give written notice of termination of the contract, within 15 days after receipt of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis.

Refrain from discriminating against individuals eligible to enroll on the basis of health status or the need for health care services.

Refrain from discrimination against individuals eligible to enroll on the basis of race, color, or national origin and will not use any policy or practice that has the effect of discrimination on the basis of race, color, or national origin.

Comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education of Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

Make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages. NOTE: Recipients can obtain assistance with language interpretation by calling the Customer Service Unit at 1-800-362-1504.

1. Receive prior approval from the Agency of any marketing materials, Patient 1st specific, or education materials prior to distribution. Materials shall not make any assertion or statement (whether written or oral) that the recipient must enroll with the PMP in order to obtain benefits or in order not to lose benefits. Materials shall not make any assertion or statement that the PMP is endorsed by CMS, the Federal or State government or similar entity.
2. Refrain from door-to-door, telephonic or any form of marketing
3. Retain records in accordance with requirements of 45 C.F.R. 74 (3 years after the final payment is made and all pending matters are closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original 3 year period ends).

4. Refrain from knowingly engaging in a relationship with the following:
 1. An individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or
 2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation. Note: The relationship is described as follows:
 - a. As a doctor, officer, partner of the PMP,
 - b. A person with beneficial ownership of more than five percent (5%) or more of the PMP's equity; or,
 - c. A person with an employment, consulting or other arrangement with the PMP for the provision of items and services which are significant and material to the PMP's contractual obligation with the Agency.

39.3.2 Hospital Admitting Privileges Requirement

Patient 1st Primary Medical Provider (PMPs) are required to establish and maintain hospital admitting privileges or have a formal arrangement with another physician or group for the management of inpatient hospital admissions that addressed the needs of all enrollees or potential enrollees. If a PMP does not admit patients, then the *Patient 1st Hospital Admitting Agreement* form must be submitted to the Agency to address this requirement for participation.

A formal arrangement is defined as a voluntary agreement between the Patient 1st PMP and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the Patient 1st enrollee throughout the inpatient stay. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a distance of thirty (30) miles or forty-five minutes drive time from the Patient 1st PMP's practice. If there is no hospital that meets the above geographical criteria, the hospital geographically closest to the Patient 1st PMP's practice will be accepted.

- a. To qualify for the additional case management fee component a PMP must admit patients or have a formal arrangement with a hospitalist group.
- b. If the PMP has a formal arrangement with another physician group, no additional monies will be paid. The providers must be enrolled as Alabama Medicaid providers, but it is not necessary that they be enrolled as Patient 1st providers. Admissions through unassigned hospital-based call groups do not meet this requirement.

Exception may be granted in cases where it is determined the benefits of a provider's participation outweigh the provider's inability to comply with this requirement.

39.3.3 24/7 Coverage Requirement

PMPs must provide enrollees with after-hours coverage. It is important that patients be able to contact their PMP to receive instruction or care at all times so that care will be provided in the most appropriate manner to the patient's condition. PMP's can meet this requirement through a variety of methods. However, only those arrangements that put the patient into contact with voice-to-voice assistance from someone associated with the physician's practice will receive the additional monies through the case management fee.

To qualify for this case management fee component, the PMP or someone on his staff, or a nurse call center must provide voice-to-voice assistance. Refer to Attachment C of the enrollment application for the amount paid for this component and indicate the arrangements made for this coverage.

A PMP may have an arrangement with another physician group or the local emergency room to provide 24/7 coverage, but will not qualify for the additional case management fee component.

An office telephone line that is not answered after hours or answered after hours by a recorded message instructing enrollees to call back during office hours or to go to the emergency department for care is not acceptable. It is not acceptable to refer enrollees to the PMP's home telephone if there is not a system in place as outlined above to respond to calls. PMPs are encouraged to refer patients with urgent medical problems to an urgent care center.

39.3.4 Standards of Appointment Availability and Office Wait Times

The PMP must conform to the following standards for appointment availability:

- Emergency care – immediately upon presentation or notification
- Urgent care – within 24 hours of presentation or notification
- Routine sick care – within 3 days of presentation or notification
- Routine well care – within 90 days of presentation or notification (15 days if pregnant)

The PMP must conform to the following standards for office wait times:

- Walk-ins – within two hours or schedule an appointment within the standards of appointment availability
- Scheduled appointment – within one hour
- Life-threatening emergency – must be managed immediately

If these standards can not be met due to extenuating circumstances, then the patient should be informed within a reasonable amount of time and given an opportunity to reschedule the appointment.

39.3.5 Patient 1st Medical Records Guidelines

Medical records should reflect the quality of care received by the client. However, many times medical records documentation for the level of care provided varies from provider to provider. Therefore, in order to promote quality and continuity of care, a guideline for medical record keeping has been established by the Patient 1st program. All Patient 1st PMPs must implement the following guidelines as the standards for medical record keeping.

1. Each page, or electronic file in the record, contains the patient's name or patient's Medicaid identification number.
2. All entries are dated.
3. All entries are identified as to the author.
4. The record is legible to someone other than the writer, including the author.
5. Medication allergies and adverse reactions are prominently noted and easily identifiable as well as the absence of allergies.
6. Personal and biographical data is recorded and includes age, sex, address, employer, home and work telephone numbers, and marital status.
7. Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
8. There is a completed immunization record. For pediatric patients (age 12 and under) there is a complete record with dates of immunization administration.
9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record.
10. Notation concerning smoking, alcohol, and other substance abuse is present.
11. Notes from consultations are in the record. Consultation, lab and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of the follow-up plans.
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for hospital admissions.
14. Documentation of individual encounters that provide adequate evidence of appropriate history, physical examination, diagnosis, diagnostic test, therapies, and other prescribed regimen, follow-up care, referrals and results thereof, and all other aspects of patient care, including ancillary services.

39.3.6 Recipient Education

Recipient education will be an integral part of the program to help the recipients understand the Patient 1st Program system and their responsibilities under such a system. The Agency has recently outlined in the Patient Handbook the recipient's rights and duties as being part of the Patient 1st Program. All educational materials have stressed the importance of contacting the PMP before receiving services, which services do not require a PMP referral, and most importantly, the 1-800 number to call anytime there is a question.

In addition, as the coordinator of care, it is important for PMPs to be actively involved in patient education. Patient 1st PMPs are strongly encouraged to contact all new enrollees by telephone or in writing. New enrollees are identified in the monthly Patient 1st Provider Enrollment Report.

Providers should address the following subjects with each new enrollee:

The PMPs requirement to provide medical advice and care 24 hours per day, 7 days per week and the preferred method for contacting the PMP.

- The requirement that the enrollee contact the PMP for a referral before going to any other doctor.
- The requirement that the enrollee must contact the PMP before going to the emergency department unless the enrollee feels that his/her life or health is in immediate danger.
- The importance of regular preventive care visits such as Well Child Check-ups (EPSDT) screenings for children, immunizations, check-ups, mammography, cholesterol screenings, adult health assessments, and diabetic screenings.
- The availability of additional information for enrollees from the Agency.

39.3.7 Non-Performance (Sanctions)

Failure to meet the terms outlined in the Patient 1st provider agreement may result in the imposition of one or more of the following sanctions:

- A limit may be imposed on member enrollment.
- All or part of the monthly case management fee may be withheld
- The PMP may be referred to Patient 1st Program Integrity (PI) or Quality Assurance (QA) Unit for investigation of potential fraud or for quality of care issues.
- The PMP may be referred to the Board of Medical Examiners.
- The PMP may be terminated from the Patient 1st program.

Medicaid makes the determination to initiate sanctions against the PMP and may impose one or more sanctions simultaneously based on the severity of the contract violation. Medicaid Legal Division may initiate a sanction immediately if it is determined that the health or welfare of an enrollee is endangered or Medicaid may initiate a sanction to begin within a specific period of time. Failure to impose a sanction for a contract violation does not prohibit Medicaid from exercising its right to do so for subsequent contract violations.

39.3.8 Non-Performance (Sanction) Appeals

The PMP is notified by certified mail of the sanction(s) and the right to appeal the sanction. Medicaid must receive the PMP's request for a formal evidentiary hearing by the Medicaid Legal Division no later than 15 calendar days from the receipt of the sanction notice. The hearing provides an opportunity for all side to be heard in an effort to resolve the issue. The sanctioned party may represent himself/herself or may enlist the services of an attorney or designate a representative. The findings are documented by the Legal Division and presented to the Commissioner who makes the final determination to uphold or rescind the sanction. The PMP is notified by certified mail of the Commissioner's decision.

PMPs that are terminated from the Patient 1st program – or voluntarily withdraw to avoid a sanction – are not eligible to reapply for a minimum of one year with a maximum time period to be determined by the Agency. The decision is predicated on the extent or severity of the contract violation, necessitating the termination.

39.4 Monthly Case Management Fee

The PMP is paid a medical case management fee per month for each recipient the PMP has enrolled, as of the first day of each month. However, Federally Qualified Health Centers, Independent Rural Health Clinics and Provider Based Rural Health Clinics do not qualify for the case management fee.

The monthly fee amount that may be paid each PMP is determined by fee components taken from the enrollment application and based on performance measures identified by Medicaid. There is no limit on the accumulation of case management fees; however, the fees paid are contingent upon the fee components the PMP agrees to and the number of enrollees on a PMP's panel with a cap set at 2,000(with extenders) enrollees. The case management fee will generally be paid on the first checkwrite of the month. The medical case management fee will be automatically generated based on Medicaid enrollment reports. Therefore, the PMP is not required to file a claim for the medical case management fee. All other services provided are reimbursed by the current fee-for-service method.

The PMP will be provided a monthly report of all enrollees assigned to the PMP prior to the first of each month. The case management fee will appear as a "rolled-up" claim on the PMP's EOB. A "rolled-up" claim is one in which all case management fees are paid as a lump sum under a pseudo Medicaid number. The provider's EOB should contain procedure code G9008.

39.4.1 Case Management Fee Components

PMP's will receive a case management fee that reflects the contractual requirements to which the PMP has agreed. The components of the fee are delineated below. Details on the components are provided so that the PMP can determine whether the component can be met. This information will be entered based on the providers Medicaid enrollment and the Patient 1st application submitted.

- **EPSDT**

If the PMP does his own screenings, then **.45** will be built into the monthly case management fee. The PMP must have a signed EPSDT agreement on file with EDS. If the PMP authorizes another provider to do his screenings on a routine basis, then he is not eligible for this component of the case management fee. This component will be auto plugged based on information on the PMP's regular Medicaid enrollment.

- **VFC (Vaccine for Children)**

If the PMP is an enrolled VFC provider, then **.10** will be built into the monthly case management fee. The PMP must have a signed VFC agreement with the Health Department. This component will be auto plugged based on information on the PMP's regular Medicaid enrollment.

- **24/7 Coverage**

If the PMP or someone on his staff, or a nurse call center provides voice-to-voice assistance, then **.85** will be built into the monthly case management fee.

- **Medical Home Project**

If the PMP completes the Medical Home Training Project then **.10** will be built into the monthly case management fee. The Medical Home Project is a training module that helps train PMPs on the components of establishing and maintaining a medical home for patients. As CMEs are received, a copy should be sent to Medicaid for inclusion in the monthly case management fee.

- **Hospital Admitting Privileges**

If the PMP admits his own patients or has arrangements with a hospitalist group to admit his patients, then **.30** will be built into the monthly case management fee. If patients have to be admitted through another provider then the PMP is not eligible for this component of the case management fee. This information will be plugged from the Patient 1st application.

- **Electronic Notices**

If the PMP agrees to receive notices from Medicaid and EDS via electronic means (not paper copies), then **.05** will be built into the monthly case management fee. This information will be auto plugged based on information on the PMP's regular Medicaid enrollment.

- **Electronic Education Materials**

If the PMP agrees to receive educational materials via electronic means and reproduce those materials for his Patient 1st patients, then **.15** will be built into the case management fee. This information will be plugged from the Patient 1st application.

- **Disease Management**

If the PMP agrees to work with the Agency and its partners to place in-home monitoring equipment on select patients, then **.10** will be built into the case management fee. The PMP will be responsible for identifying patients and reviewing monitoring reports provided on the patient's condition(s). This information will be obtained from the Patient 1st application.

- **InfoSolutions**

If the PMP agrees to work with BC/BS and utilize their InfoSolutions Pharmacy Program, then **.50** will be built into the case management fee. This information will be plugged from the Patient 1st application.

- **Performance**

Additional case management monies will be paid to the PMPs meeting performance measurements as defined by the Agency. The additional case management fee will be based on the total amount of savings and the percentage of measures met by the PMP.

39.5 Monthly Reports of Enrollees

The following reports are provided to PMPs to help identify and manage patients on their panel.

39.5.1 *Initial Assignment Listing*

This report will list new patients that the Agency has assigned for a future date (approximately 45 days) and consists of the following recipient information:

- Name
- Address
- Medicaid Number
- Date of Birth
- Aid Category
- County of Residence

The PMP should use this list to gauge caseloads, ensure service can be provided to all enrollees, and to determine if any patients have previously been dismissed. This list is not final, as the patient will have until the 20th of the month preceding the enrollment date to change.

39.5.2 *Monthly Enrollee Listing*

The first of each month, the PMP will receive a listing of all enrollees that are the responsibility of the PMP for the month, as well as those that have been added or deleted. This listing will include the recipient's demographic information, Medicaid number, aid category, reason assigned to PMP, county code and review date. The enrollee status will be noted as new, continuing, or deleted.

- New Enrollees – future enrollees who have 45 days to change their PMP if they choose

- Continuing Enrollees – enrollees that have been previously assigned and continue to be assigned to the PMP
- Deleted Enrollees – enrollees that have been deleted from the PMP's panel. A reason code will be listed on this report to explain why the enrollee was deleted from the panel. The explanation of the reason code will be listed on the last sheet of the enrollment report.

In addition a cover sheet will be included that provides information about the PMPs panel and will list the following:

- Counties – current counties in which the PMP has agreed to see Patient 1st eligibles
- Current Caseload – the number of patients currently assigned to the PMP
- Maximum Caseload – the maximum caseload that can be assigned
- Age Criteria – the age range of enrollees the PMP specified he/she wanted on their panel
- PMP List – indicates if the PMP wants to be included on the Patient 1st Providers Listing (county specific)
- Case Management Fee – the case management fee amount paid to the provider based on the case management components he/she agreed to participate in.

It is the PMP's responsibility to review this report every month and report any errors to Medicaid. PMP's must continue to coordinate care for any enrollees who are linked to the practice, even if a change has been requested or an error has been reported until the change or error has been resolved and reported correctly.

If the report is not received by the first of the month, a replacement list can be requested by calling the Provider Assistance Center at 1-800-688-7989.

NOTE:

This list is not a substitute for eligibility verification. All providers should always verify Medicaid eligibility prior to rendering services.

39.6 Eligible Recipients

The Agency is responsible for recipient enrollment in Managed Care programs. Patient 1st is mandatory for most Medicaid recipients. Medicaid eligibles that must participate in **Patient 1st** are those for whom eligibility has been determined as listed below. Eligibility categories include:

SOBRA eligible children
MLIF and MLIF related
Refugees
Blind
Disabled
Aged

Infants of SSI mothers

Medicaid recipients in the above categories of Medicaid eligibility are **excluded from participation in Patient 1st in the following circumstances**. NOTE: Those categories with an asterisk are not automatically removed from the Program. These individuals must be reported to Patient 1st for removal from the program. Removal from Patient 1st does not affect their normal Medicaid benefits.

Medicaid eligibility is retroactive only;

Recipient is enrolled in another managed care program in which access to primary care physician is limited (i.e., HMO);*

Recipient is a lock-in;

Recipient resides in a residential or institutional facility such as a nursing home or ICF/MR or a group or foster home or DYS (Department of Youth Services);*

Recipients with dual eligibility (Medicare and Medicaid); and

Recipients who have been determined to be Medically Exempt for the Patient 1st Program, including:*

Terminal illness – the enrollee has a life expectancy of six months or less or is currently a hospice patient,

Developmental delay or Impaired Mental Condition – the enrollee does not possess the ability to understand and participate in Patient 1st (Note: This statement is not a determination of the patient's legal mental competence),

Chemotherapy or Radiation treatment – the enrollee is currently undergoing treatment (Note: This is a temporary exemption that ends when the course of treatment is completed. If the therapy will last for more than six months, the exemption must be requested after the initial six-month time period during reapplication for Medicaid coverage,

Continuity of Care issues (Note: A temporary exemption may be granted to allow a Patient 1st enrollee to continue to see a non-participating physician while the physician is in the process of applying for participation in Patient 1st), and

Diagnosis/Other – an enrollee may be granted an exemption if there is a specific diagnosis or other reason why the enrollee would not benefit from coordinated care through a PMP.

The **Patient 1st Medical Exemption Request form** must be completed by the enrollee's physician and mailed to the Patient 1st Program, Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36103. A copy of the form is included in Appendix E and on the Agency's website at www.medicaid.state.al.us.

Recipients are removed from **Patient 1st** participation if they are changed to an excluded aid category, or if they lose eligibility or change county of residence. Dependent upon when a person becomes Medicaid eligible, they may not yet be enrolled in **Patient 1st**.

If you have a patient who is enrolled in **Patient 1st** who should not be enrolled, please contact the Customer Service Unit at 1-800-362-1504.

Eligibility verification indicates enrollment status and assigned PMP name and telephone number.

39.7 Recipient Enrollment/Assignment

39.7.1 Enrollment

To facilitate enrollment into the Patient 1st Program, recipients required to participate are assigned a PMP. Recipients have the ability to change PMP providers on a monthly basis. Dependent upon when a person became Medicaid eligible, they may not yet be enrolled in Patient 1st. **Always verify eligibility.**

Recipients who are added to the eligibility file (refer to 39.7.2 below for information regarding newborns) are notified of their Patient 1st assignment approximately 45 days prior to the effective date of the assignment. The purpose of the 45-day lead time is to allow recipients to change providers prior to actual PMP assignment. A second notification will be mailed to recipients approximately 5 days prior to assignment, which will confirm the original assignment if no change is made, or confirming the requested change. Providers will be notified at the same time as recipients of assignments. The assignment process takes into account group practices and/or clinic affiliation.

The computer assignment algorithm is as follows:

Newborn Will check for the person to be on the newborn list sent from the state.

Sibling Will check to see if a sibling is in the program based on payee number. If there is no payee number, then this step cannot be considered. Siblings already enrolled or those in the same batch will be considered. If two siblings are enrolled and assigned to different PMPs, then the new sibling will be assigned to the PMP of the youngest sibling.

Last PMP on file will be checked. If caseload and age criteria can be met, then assignment will be made to that PMP.

Historical Claims history will be considered for 18 months.

Random assignment based on PMPs within the recipient's county as long as caseload is available and age criteria can be met.

Random assignment is predicated on lowest available caseload on a rotating basis.

39.7.2 Newborns

Mothers of infants who will be required to participate in the program have the opportunity to select the provider they want for their child's PMP prior to assignment by the Agency. This is accomplished through the completion and submission of a Newborn Assignment Form. These forms are available through a variety of sources including, but not limited to, the physician's office, the Maternity Care Program Care Coordinator, the hospital and Medicaid's Outreach and Education Unit. The form must be completed and submitted prior to the Agency's assignment of the infant. Newborn assignments may be mailed to the Patient 1st Program or faxed to (334) 353-3856. In order for the request to be granted, the PMP must have available caseload for the recipient's county.

39.7.3 Eligibility Verification

It is the provider's responsibility to verify that a person is eligible for Medicaid at the time of service. There are three sources available for obtaining recipient information:

The Provider Electronic Solution (PES) is a point of service device or PC based software system, which accesses recipient information.

The Automated Eligibility Verification and Claims Submission (AEVCS) may be accessed by dialing 1-800-727-7848 using a true touch-tone telephone. This is an automated telephone system available approximately 21 hours a day, 7 days a week.

The Provider Communications Unit at EDS can be reached at 1-800-688-7989 from 7:30 am – 5:00 pm, Monday through Friday.

The verification will give contact information for the recipient's assigned PMP.

39.7.4 Recipient Changes of Primary Medical Providers

Enrollees may request to change their PMP at any time. The Agency is responsible for processing an enrollee's change request. Enrollees can change PMPs by calling the 1-800 line, or by mailing or faxing a written request to the Agency. The Agency monitors the reasons for change as part of the program compliance protocol.

Recipients must initiate changes to their PMP assignment

Enrollments and disenrollments to effect a change in PMP are effective the first of the month, following the date of the change if the request for change is received by the Agency by the 20th of the month. If requests for changes are received after the 20th, the change is effective the 1st of the following full calendar month.

NOTE:

If changes are not received by the 15th of the month, assurances for an effective date for the first of the following month can not be given. This will allow a 5 day processing timeframe.

Please see Appendix E of the Medicaid Provider Manual for a copy of the PMP change form that can be utilized by the recipient. Patient requested changes are confirmed by a mailing prior to the 1st of the month in which the change is effective.

39.7.5 PMP Request Change/Dismissal of Recipient

A PMP may request removal of a recipient from his panel due to good cause*. All requests for patients to be removed from a PMP's panel should be submitted in writing and provide the enrollee 30 days notice. The request should contain documentation as to why the PMP does not wish to serve as the patient's PMP.

*According to the guidelines listed in the 1915(b)(i) waiver of the Social Security Act that allows operation of the Patient 1st program, good cause is defined as:

- Behavior on the part of the recipient which is disruptive, unruly, abusive or uncooperative to the extent that the ability of the provider to provide services to the recipient or other affected recipients is seriously impaired,
- Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment; or
- Fraudulent use of the Medicaid card.

Additionally, a Patient 1st enrollee may be disenrolled for nonpayment of co-payments or an outstanding balance if this is a standard operating procedure for the practice, is applicable to all patients regardless of payer source, and prior written notice has been provided to the enrollee.

The PMP is responsible for sending a letter of dismissal to the enrollee and include a copy as an attachment to documentation provided to Medicaid. The dismissal letter should be addressed to the patient and signed by the PMP. Another PMP, not one in the same group as the original PMP, will be selected for the recipient.

Recipients will be given the opportunity to change the selected PMP before the active assignment date. **The original PMP must continue to provide services or make referrals for services to the recipient until such time the reassignment is complete.** All reassignments will be made effective the 1st of a month.

Dismissal requests should be faxed to the Patient 1st Program at (334) 353-3856.

39.7.6 PMP Disenrollment

Patient 1st enrollees are assigned to a different PMP if a PMP dies, moves out of the service area, or loses Medicaid and/or **Patient 1st** provider status. Such reassignment is usually accomplished by automated means. Medicaid sends a notice to the affected recipients, telling them of the reassignment, and the reason for the reassignment. They may then select another PMP if the reassignment is not satisfactory.

PMP Leaves Group Practice

If it is a situation of a PMP leaving the area, then patients will be reassigned to the remaining practitioner or group.

PMP Site Change

If it is a situation of a PMP leaving one site to open another site, the patients will be reassigned to the remaining practitioner.

PMP Closing a Site

If it is a situation of a PMP maintaining two locations within the same geographical area, then the patients from the closed site will be reassigned to the site remaining open. This will apply if the PMP is maintaining a group or clinic site or private practice site.

39.8 Referral Process

Coordination of care is an important component of Patient 1st. PMPs are contractually required to either provide services or authorize another provider to treat the enrollee while adhering to the referral process. This applies even when an enrollee has failed to establish a medical record with the PMP. The patient does not have to be seen by the PMP prior to a referral being given.

PMPs may make referrals to any practitioner that can best meet the patient's needs. However, every effort should be made to refer patients to Medicaid enrolled physicians that are geographically accessible to help facilitate the reimbursement process.

In some cases, the PMP may choose to authorize a service retroactively. All referrals, including services authorized retroactively, are at the discretion of the PMP. Some services do not require referral; refer to Section 39.10 of this Chapter for more information.

In addition to Patient 1st PMP referral, prior approval (PA) may be required to verify medical necessity before rendering some services. PA is for medical approval only. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. Refer to Chapter 4, **Prior Approval** of the Medicaid Provider Manual for additional information about services requiring PA.

39.8.1 Referral Form

All referrals must be documented on the *Alabama Medicaid Agency Referral Form (Form 362)*. Medicaid requires that the referral form be used **for each referral authorization given**.

Referral authorization from the PMP must be given prior to patient treatment. If given verbally, **** a written referral form, from the PMP to the consultant, must follow within 72-hours of the verbal authorization.**

A copy of the referral form is included in Appendix E (Medicaid Forms) of this manual. In addition, the form can be obtained by accessing Medicaid's website or by contacting the Outreach and Education Unit. See section 30.14 for instructions.

39.8.2 *Comprehensiveness / Duration of Referral*

The comprehensiveness and duration of the referral is determined by the PMP and the other provider. The referral may cover one visit or it may cover multiple visits as long as those visits are part of a plan of care and are medically necessary. A new approval must be provided if the diagnosis, plan of care or treatment changes.

If the consulting physician decides that the recipient must be treated by another consulting physician (or another provider who is not the PMP), the first consulting physician must contact the PMP for approval and authorization to further refer the patient, unless such approval has already been **indicated on the referral form**. The second provider should then use the PMP's approval code when billing. This same procedure should be followed for **any** successive referrals.

Referrals can be for duration of up to 12 months for EPSDT referred services. Referrals from a previous PMP may be honored for a 6 month time frame. The referral number is the PMP's provider number. If the PMP is with a Clinic/ Group, the referral number is the Clinic's/Group's provider number.

39.8.3 *EPSDT Screening Referrals*

It is not necessary to redo EPSDT screening referrals on the Patient 1st/EPSDT Referral form. If the original screener is not the PMP, then the PMP must either sign on the original Patient 1st EPSDT referral form (anywhere is acceptable) or issue a written **Patient 1st** referral. Please refer to the Appendix A of the Medicaid Provider Manual. In addition, screenings performed prior to enrollment as Patient 1st are acceptable as long the PMP concurs with the findings and treatment plan.

39.8.4 *Group/Clinic Practices*

Physicians within the same group/clinic and enrolled at Medicaid with a group/clinic number are not required to have referrals among the group/clinic physicians. If a group/clinic physician is covering for another PMP, and a patient requires a referral to a provider outside the group/clinic, then the authorization number of the assigned PMP must be provided to the referred provider and noted in the chart.

39.8.5 *Referral for Coverage of Non-Group/Clinic Physicians*

When a physician is providing coverage for a PMP (outside of a formal group practice) and services are rendered to an enrollee, the covering physician must provide the PMP with documentation as to the nature of the services rendered and any follow-up required for placement in the patient's medical record. The PMP must provide the covering physician with a referral authorizing such coverage in order to facilitate reimbursement.

39.8.6 *Referral for a Second Opinion*

Patient 1st PMPs are required to refer an enrollee for a second opinion at the request of the enrollee.

39.8.7 Referrals for Non-Established Patients

The Agency understands that it may be the policy of a PMP not to issue a referral unless the patient is established. We can appreciate the need to know a patient in order to appropriately manage his or her care. However through **Patient 1st**, new patients are continually added—patients which the PMP may not have an established relationship. If a patient who is a new patient or one who has not consulted with the PMP requests a legitimate urgent referral, we suggest that you issue the referral and use this opportunity to schedule a follow-up visit. If the patient refuses to follow-up with a visit to your office at that time, it would be appropriate to refuse further referrals or pursue the option of dismissing the patient if behavior is deemed to be of a non-compliant nature. See “PMP Request Change/Dismissal of Recipient”.

Keep in mind that many of these patients have changed their PMP assignment to the physician to whom they are currently seeing or have been seeing in the past. For one month, the patient may be assigned to you as a PMP. If a referral is necessary during this one month, then it can be documented as a billing referral only.

NOTE:

PMP referral grants access only to service, it does not supersede benefit limits and/or other authorization processes. Please refer to the Appendix E for Patient 1st services that require a referral and services that **do not** require a referral.

39.8.8 Special Authorizations

There are situations in which a PMP may be requested to authorize Medicaid services for a recipient who no longer lives in the service area, who changes eligibility categories and is no longer in a category covered by **Patient 1st**, or who has changed PMPs. Examples for the most common of these situations are given below:

Example 1

The recipient moves to another **Patient 1st** county and selects another PMP. If the recipient needs medical care and his/her county has not been changed (perhaps in the middle of the month), the provider must contact the PMP for authorization of services.

Example 2

A child is removed from an MLIF case because he/she is now in foster care and eligible for Medicaid under the foster care program. If the child needs medical care during the period that his/her **Patient 1st** still is in effect (usually in the middle of the month), the provider must contact the PMP for authorization of services in the same manner as described above.

39.8.9 Referral for Billing Purposes Only

A PMP may approve a referral for billing purposes only. Such a referral should be documented "for billing purposes only" on the standard billing referral form in the space provided under REFERRAL VALID FOR. The billing procedure for this type of referral is the same as all other referral types.

39.8.10 Billing for Referred Services

The nine-digit PMP number must be reflected on either the CMS -1500 by the specialty physician or on the UB-92 if a hospital or outpatient clinic is providing the specialty services. If this field is not properly coded, Medicaid will reject the claim. Please refer to section 39.8.11 for details on how to bill for referred services.

A pharmacist does not have to contact the PMP prior to filling a prescription written by another Medicaid provider, but must enter on the claim form the license number of the prescribing physician.

If a Patient 1st enrollee goes to any other Medicaid provider for non-emergency services without the referral of the PMP for Patient 1st services, the provider should refer the enrollee back to the PMP or contact the PMP. If the PMP authorizes the services at that time he/she will give the provider his/her provider number for entry on the claim form and Medicaid will pay the claim if the enrollee is eligible and has benefits available. If the Medicaid recipient insists upon receiving the unauthorized service, he/she should be informed that Medicaid will not pay the claim and that the recipient will be responsible for payment of services rendered.

39.8.11 Authorization Number

Access to services is authorized through use of the PMP's nine digit Medicaid Provider Number. To facilitate the process, and lessen the administrative burden for the physician, the following procedures are used when processing claims:

Step One (Billing Provider)

The **PMP** provider number on the claim is compared against the **PMP** provider number to whom the recipient is assigned. If they match, the claim continues through Medicaid edits.

The group number of the provider on the claim is compared against the group number on the PMP file. Groups are assigned a group number. If they match, the claim continues through Medicaid edits. 'Informal' groups are not considered to be a group as they cannot be identified systematically.

The unique number of the provider on the claim is compared against the unique number on the PMP file. If they match, the claim continues through Medicaid edits.

Step Two (Referring Provider)

The referring **PMP** provider number indicated on the claim is compared against the provider number to whom the recipient is assigned. If they match, the claim continues through Medicaid edits.

The referring **PMP** group number on the claim is matched against the group number on the PMP file. If they match, the claim continues through Medicaid edits.

The referring **PMP** unique number on the claim is matched against the unique number on the PMP file. If they match, the claim continues through Medicaid edits.

If the claim is for **Patient 1st** coordinated services and steps one and two do not apply, the claim will be denied with an **EOB** Code of **107**. A **107** denial code means 'Recipient enrolled in the **Patient 1st** Program, services require referral from PMP'.

When making referrals, the PMP must provide the nine digit Medicaid provider number to be used by the consulting provider. All PMP referrals must be in writing. The PMP may make the referral verbally, but must follow with a written referral to the requesting physician within a 72-hour period of the verbal authorization.

39.8.12 Override Requests

In extenuating circumstances, on a case-by-case basis, and after thorough review, Medicaid may determine that a referral override may be prudent in some situations. Providers must request an override using the **Patient 1st Override Request form** to obtain payment. A copy of the **Patient 1st Override Request form** is in Appendix E of the Medicaid Provider Manual. Override requests must be submitted to the Patient 1st Program by mail within six months of the date of service. Requests will be evaluated within 30 days of receipt. Overrides will not be approved for well visits.

39.9 Complaint / Grievance Process

39.9.1 Filing a Complaint or Grievance

Enrollees can file complaints or grievances through the 1-800-362-1504 Recipient Inquiry telephone line or in writing by submitting a Patient 1st Complaint form to the address indicated on the form (a copy of the form is available in Appendix E or from the Agency). Providers can file complaints or grievances through Medicaid's Customer Service Unit at 1-800-362-1504 or in writing. Enrollees or Providers may file complaints or grievances about their assigned provider or other aspects of the **Patient 1st** Program system. Medicaid's Managed Care QA Program will thoroughly investigate each complaint or grievance and report the results of its findings back to the enrollee or provider. When appropriate, the enrollee's assigned provider will be notified to document the complaint and obtain necessary correction of problems noted. In especially acute situations, Medicaid may use the special authorization system or various procedure exception systems to resolve the grievance. The enrollee may appeal the action or may request a formal Medicaid hearing. Complaints by other providers or reports by informants are investigated similarly to grievances.

39.9.2 Grievance Log

Medicaid will maintain a log of the grievances received and their disposition. Complaints/Grievances will be "categorized" as a tool by which to assess program impact. Complaints/Grievances usually fall into one of the following five categories:

1. Contract violations/program policy
2. Professional conduct – general
3. Professional conduct – physical, sexual or substance abuse
4. Quality of care
5. Program fraud/abuse

39.10 Detail on Select Services

39.10.1 Benefits

Patient 1st enrollees have the same range scope, amount of services and co-payments as other Medicaid recipients. There are some services that are excluded from the **Patient 1st** program and do not require authorization by the PMP. These are obtained through the same procedure as used by other Medicaid recipients outside the Patient 1st program. It is anticipated; however, that the enrollee will look to the PMP for advice and/or coordination of these services. **Patient 1st** enrollees should be offered the same level of service coordination for non-authorized services as would other patient populations.

The **Patient 1st** Program does not extend or supersede any existing program benefit or program requirement. A matrix of what services **do** and **do not** require referral follows.

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

10/01/04

Service	Claim Type	System Identification
Allergen/Immunotherapy	M	Procedure Codes 95115-95199 (Administration of allergy injections)
Ambulance	M	Ambulance-Ground and Air
CRNA	M	Certified Registered Nurse Anesthetist
Certified Emergency	M OP	Any service rendered by a provider resulting from a documented certified emergency (utilize claim block 24-I with an "E" indicator on the CMS -1500 Claim Form; utilize claim block 78 with an "E" indicator on the UB-92 Claim Form.)
Dental	M DE OP	Dentists & Federally Qualified Health Centers (Claim Type DE only), Clinics- Children's Dental/Orthodontia and Orthodontists, Oral, Maxillofacial Surgeons Procedure Codes: D8080 (Comprehensive orthodontal treatment of adolescent dentition), D8680 (Orthotic retention-removal of appliances, construction/ placement of retainers), D9430 (Office visit for obs services during regular hours) Outpatient facility procedure codes D9420. Note: OP facilities do not require a referral for DENTAL procedures.
Dialysis	OP	Dialysis Centers
EEG/EKG Related Services	M OP	Procedure Codes: 93000-93278 (Routine ECG w/at least 12 leads w/interpretation & report), 95805-95827 (EEG related services)
End Stage Renal Disease	M	Nephrologists Diagnosis Code: 585 (End Stage Renal Disease)
EPSDT Developmental Diagnostic Assessment	M	Procedure Codes: 96110 & 96111 (EPSDT Developmental Assessment) NOTE: Other EPSDT requires referral
Eye Exams, non-medical	M	Optometrists Procedure Codes: 92002-92015, 92313 (Corneoscleral lens) NOTE: Ophthalmological services require referral
Eyeglass & Other Lens Fittings	M	Procedure Codes: 92340-92355 (Fitting of spectacles), 92310-92312 (Prescription/fitting for contact lens-medical supervision of adaptation)
Eyeglasses/Lens	M	Procedure Codes: V0100-V2799 (CMS Assignment of Vision Services), V2020 (Standard Eyeglasses, Frames), V2025 (Eyeglasses, Special Order Frames, 92315-92317 (Corneal Lens/Corneosclera Lens) 92326 (Replacement of Lens), 92370 (Repair of spectacles)
Factor 8	ANY	Procedure Codes: J7197, J7198, J7199(Anti-Inhibitor Coagulant Complex), J7193, J7194, J7195(Factor IX Complex-Per IU)

M=Medical (CMS 1500)

IP=Inpatient

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DE=Dental

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

10/01/04

Service	Claim Type	System Identification
Family Planning <ul style="list-style-type: none"> Medical Outpatient 	M O	Medical Outpatient: Family Planning Indicator (Y) – Procedure Codes: 58300-58301 (Insert intrauterine device), 58600 (Ligat/Trans of fallopian tubes), 58605 (Ligat/Trans of fallopian tubes), 58611 (Ligat/Trans of fallopian tubes), 58615 (Ligat/Trans of fallopian tubes), 50610 (Initial visit), Birth control pills, Adolescent pregnancy prevention education, Hormonal IUD, 11975-11977 (Insertion/Removal of contraceptive capsule), 55250 (Vasectomy), 55450 (Ligation: vas deferens), 58670-58671 (Laproscopy), 57170 (Diaphragm fitting), Depo Provera; Diagnosis Codes: V25-V2590 (Contraceptive Management)
Glucose Test Strips/Lancet	M	Procedure Codes: A4253 (Blood Glucose Test/Reagent Strips for Home Blood Glucose per box of 50 - limited to 3 boxes per month), A4259 (Lancets, per box of 100 - limited to 2 boxes per month) NOTE: Requires prior authorization if additional strips and/or lancets are needed.
Gynecology/Obstetrics	M	OB/GYN-Any service performed by this specialty is exempt from referral requirement. Note: OP facility fees for OB/GYN services require a PMP referral unless for Family Planning or Maternity Services as defined herein.
HCBS Services	M	Providers of HCBS waived services i.e. Elderly & Disabled Waiver-ED, Homebound Waiver-EC, and MR/DD Waiver-EE)
Hearing Aids	M	Hearing Aid Dealers (EPSDT only)
Hospice	OP	Hospice
Immunizations	M OP	Administrative Fees for Procedure Codes: 90700-90748 (Immunization, Active DTAP for intramuscular use), 90645 (HIB Vaccine), 90647-90648 (HIB Vaccine), 90657-90658 (HIB Vaccine), Factor IX Complex, per IU, Rhogham Serum, Pneumovax 23, Pnu-Imune 23, Fluzone, DT Toxoid, Fluzone-Subviron, Recombivax-Hep B, Haemoph B Prohibit, Hepatitis B-Energix B, Antihemophilic Factor
Infant Birth Diagnosis	ANY	Diagnosis Codes: V30-V3911 (Single Liveborn)
Inpatient Consults	M	Procedure Codes: 99251-99263 (Initial inpatient consult), 99360 (Physician Standby), 99436 (Attendance at delivery)
Inpatient Hospital <ul style="list-style-type: none"> General Psychiatric Physician Hospital Visit 	IP	Hospital

M=Medical (CMS 1500)

IP=Inpatient

OP=Outpatient

DE=Dental

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

10/01/04

Service	Claim Type	System Identification
Laboratory	M	Independent Labs & Hospitals-(Claim Type OP) - Outpatient Hospital Lab Services-Procedure codes: 36415 (Routine Venipuncture), 36416 (capillary blood specimen), 80048-89399 (Pathology & Lab Organ or Disease Panels); Outpatient Hospital Chemotherapy-procedure codes: 96400-96549 (Chemotherapy Administration)
Long Term Care (LTC) <ul style="list-style-type: none"> Intermediate Care Facility-Mentally Retarded (ICF-MR) Nursing Home 	IP	Nursing Homes & ICF-MR Facilities
Maternity Care Program	M	Maternity Care Program-Primary Caregiver
Maternity Services	M OP	Diagnosis Codes: 640-67699 (Pregnancy-related)
Mental Health Services	M	Mental Health Services NOTE: Includes Community Mental Health Centers and other providers with same provider type. PMP notification is required for services rendered.
Newborn Care	M	Procedure Codes: 54150 (Circumcision/clamp), 54160 (Circumcision/surgical), 99440 (Newborn resuscitation), 99431-99436 (History/exam of newborn), 99360 (Physician Standby)
Optometrist/Optician	M	Optometrist/Optician
Physicians	M	Anesthesiologists, Oral & Maxillofacial Surgeons, Pathologists, Radiologists/Diagnostic, Nuclear Medicine Physicians **All other physicians require referral in any office or outpatient setting.
Pregnancy-Related Services	M IP OP	Diagnosis Codes: 640-67699 (Pregnancy-related), V22-V242 (Normal pregnancy-routine postpartum f/u), V27-V289 (Outcome of delivery)
Preventive Education	M	County Health Department, Preventive Ed
Professional Component	M	Modifier 26; Procedure Codes: 93010 (Interpretation/Report of Cardiography), 93237 (Physician review/report), 93300-93399 (Echo)
Radiology	M	Independent Radiologists & Hospitals (Claim Type OP) Outpatient Hospital Radiology-procedure codes: 70010-79999 (Diagnostic Radiology)

M=Medical (CMS 1500)

IP=Inpatient

OP=Outpatient

DE=Dental

PATIENT 1ST SERVICES REQUIRING PMP REFERRAL**10/01/04**

Service	Claim Type	System Identification
Ambulatory Surgical Center	OP	Lithotripsy other than physicians and centers NOTE: Includes Ambulatory Surgical Centers and Lithotripsy
Anesthesia	M	Physicians EXCEPTION: Anesthesiologists
Audiologists' Services	M	Audiologists (EPSDT ONLY)
Chiropractor Services	M	Chiropractors. (EPSDT or QMB recipients only)
Clinics	M DE	Clinics EXCEPTION: Children's Dental & Children's Orthodontia (Orthodontist) Procedure Codes: 08080 (Comprehensive orthodontal treatment of adolescent dentition), 08680 (Orthodontic retention-removal of appliances, construction/placement of retainers), 09430 (Office visit for obs services during regular hours)
County Health Department	M	EXCEPTION: County Health Department/Preventive Education
Durable Medical Equipment	M	Durable Medical Equipment-DME
EPSDT Screenings	M	Procedure Codes: 99381-EP – 99385-EP Initial, 99381-EP – 99395-EP(Periodic; 99391-99395 w/o EP modifier (Interperiodic); 99173-EP(EPSDT Vision Screening), 92551-EP (Hearing Screening).
FQHC Services (Federally Qualified Health Center)	M	FQHCs EXCEPTION: Family Planning Indicator (Y)
Home Health	OP	Home Health Providers NOTE: Inpatient services do not require a referral, however, discharge planning of outpatient services (i.e. home health, DME, specialist visits) do require a PMP referral.
Independent Nurse	M	Independent Nurses
Nephrology	M	EXCEPTION: Nephrologists-Diagnosis Code: 585 (End Stage Renal Disease (ESRD))
Optometrist/Optician Svcs	M	Optometrists/Opticians), for medical diagnosis.
Outpatient Hospital Services	M OP	Hospitals-Procedure Codes: 99281-99285, outpatient surgical procedures and therapies (PT, ST and OT), observation beds and non-certified emergencies. EXCEPTION: Outpatient Hospital Radiology (procedure codes: 70010-79999); Outpatient Hospital Lab Services (procedure codes: 36415, 80048-89399); Outpatient Hospital Chemotherapy (procedure codes: 96400-96549) Outpatient Dental L8000, L8010, L8020, L8030.
Physicians	M	Physicians-any billing by physicians unless the particular provider type or service is excluded EXCEPTION: Anesthesiologists, Oral & Maxillofacial Surgeons, Pathologists, Radiologists/Diagnostic, Nuclear Medicine Physicians
Podiatrists' Services	M	Podiatrists (EPSDT and QMB only)
Private Duty Nurse	OP	Private Duty Nurses (EPSDT only)
Psychologists' Services	M	Psychologists (EPSDT only)
Rural Health Clinics	M	Rural Health Clinics
Therapists' Services	M	Physical Therapists, Occupational Therapists and Speech Therapists. Outpatient therapy services must be a result of an EPSDT or for QMB recipients.

M=Medical (CMS 1500)

IP=Inpatient

OP=Outpatient

DE=Dental

39.10.2 *Emergency Services*

Access to certified emergency services will not be restricted by the **Patient 1st** Program. Certified emergencies in outpatient emergency room settings do not require referral or prior authorization by the PMP. However, documentation should be maintained by the provider of service to support emergency certification.

39.10.3 *Certified Emergency Services*

A certified emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

The attending physician is the only one who can certify an emergency visit. In determining whether a claim should be submitted and documented as a certified emergency, consider the following guidelines:

The case should be handled on a situational basis. Take into consideration the person presenting, their medical background, extenuating circumstances, presenting symptoms, time of day, and availability of primary care (e.g., weekend, night or holiday.)

Determine whether the presenting symptoms as reported would be reasonably expected to cause the patient to expect a lack of medical attention could result in an unfavorable outcome.

Document why this case is a certified emergency. Documentation does not need to be extensive but should justify the certification.

If not an emergency, **do not certify** the visit. Note that follow-up care should not be certified as an emergency (i.e. physical therapy, suture removal, rechecks, etc.)

Ancillary or billing staff is not permitted to certify. Certification must be done by the attending physician.

Children or adults brought to the ER for exam due to suspected abuse or neglect may be certified by virtue of the extenuating circumstances.

Hospitals and physicians who provide "certified emergency" services in the Emergency Room (ER) are not required to have a referral from the PMP. Please note that follow-up care should not be certified as an emergency and in some cases may require PMP referral (i.e. physical therapy, suture removal, rechecks, etc.).

In order for the claim not to require a Patient 1st referral, there must be an "E" indicator in the appropriate claim block (CMS 1500 - block 24 I and UB 92 - block 78). Refer to the Chapter Five of the Billing Manual for further instructions.

Providers should bill certified emergency services separately from those of non-certified emergency services, which require PMP referral.

The Agency stresses the importance of coordinating with the PMPs regarding the care of Medicaid recipients in order to preserve the continuity of care and the "medical home" concept of the Patient 1st program.

39.10.4 EPSDT Services

For recipients of Medicaid, birth to age 21, the EPSDT Screening is a comprehensive preventive service at an age appropriate recommended schedule. It is the only reimbursable preventive medical service for this age group. There are numerous components of the EPSDT, all of which are required in the Federal Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) program. All age appropriate components must be performed at the time of a screening exam. These components are listed and described in Appendix A of the Alabama Medicaid Provider Manual.

PMP's are requested to either perform or make arrangements for EPSDT screenings. The PMP is responsible for ensuring that age appropriate EPSDT screenings are provided. If a PMP cannot or chooses not to perform the comprehensive EPSDT screenings, the PMP may authorize another provider serving the PMP's county to perform the screenings for enrollees in the birth to 21 year age group.

If the PMP enters into an agreement with a screener in order to meet this Patient 1st requirement for participation, the agreement containing the original signatures of the PMP or the authorized representative and the screener or an authorized representative must be submitted within the enrollment application. The PMP must keep a copy of this agreement on file. If this agreement is executed after enrollment a copy must be submitted within ten (10) days of execution.

The agreement can be entered into or terminated at any time by the PMP or the screener. The Agency and EDS must be notified immediately of any change in the status of the agreement.

If there is an agreement between the PMP and a Screener to provide EPSDT services, the PMP agrees to:

- Refer Patient 1st patients for EPSDT screenings. If the patient is in the office, the physician/office staff will assist the patient in making a screening appointment with the Screener within ten (10) days.
- Maintain, in the office, a copy of the physical examination and immunization records as part of the patient's permanent record.
- Monitor the information provided by the Screener to assure that children in the Patient 1ST program are receiving immunizations as scheduled and counsel patients appropriately if found in noncompliance with well child visits or immunizations.
- Review information provided by the Screener to coordinate any necessary treatment and/or follow-up care with patients as determined by the screening.
- Notify the Agency and EDS immediately of any changes to this agreement.

The Screener must agree to:

- Provide age appropriate EPSDT examinations and immunizations within sixty (60) days of the request for patients who are referred by the PMP or are self-referred.
- Send EPSDT physical examination and immunization records within 30 days to the PMP.
- Notify the PMP of significant findings on the EPSDT examination or the need for immediate follow-up care within 24 hours. Allow the PMP to direct further referrals for specialized testing or treatment.
- Notify the Agency and EDS immediately of any changes to this agreement.

Immunizations

Immunizations do not require PMP referral; however, the PMP must maintain documentation of immunizations received. Documentation must include: the date the immunization was given, the type of immunization, and who provided the immunization. PMPs are required to ensure that immunizations are up-to-date for children in their panel.

Providers should be aware that through **Patient 1st** new patients will be assigned, many of which, will be children. These children will be looking to the PMP for immunizations and/or documentation of immunizations, especially in the months prior to school starting. PMPs should be prepared to immunize these children or make arrangements to get appropriate information from the immunizing provider to meet the school rush. **ALL PMPs SHOULD MAKE EVERY EFFORT TO WORK WITH OTHER PROVIDERS IN THE COMMUNITY TO ENSURE THAT ALL CHILDREN ARE FULLY AND APPROPRIATELY IMMUNIZED.**

EPSDT Care Coordination

Effective March 1, 2004, the Alabama Medicaid Agency initiated an EPSDT care coordination service available for private and public providers. The goal of these services is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood.

Care coordination services are available for eligible children from birth through 20 years of age at no cost to any provider who wishes to utilize them. The Agency, along with the Department of Public Health, identifies children at greatest risk who have potential for effective intervention. These Medicaid eligible recipients are targeted for outreach.

The scope of services is designed to support the physician's office personnel in identifying, contacting, coordinating services and providing office visit follow-up for children. Areas targeted include:

- Under utilization of EPSDT and immunization services,
- Vision/Hearing Screenings, including Newborn hearing screening follow-up,
- Dental Screenings,
- High utilization of Emergency Room visits,
- Elevated Blood Lead levels,
- Abnormal Sick Cell and Metabolic Screening results,
- Referral follow-up,
- Missed appointment follow-up
- Outreach for At Risk children, and
- Teen Pregnancy Prevention Services coordination.

In addition, care coordinators are available to assist with transportation services. Care coordinators may receive referrals from physicians and dentists regarding Medically-at-Risk clients who need assistance with keeping appointments and obtaining follow-up care. Lastly, care coordinators will encourage and assist in recruiting private physicians to improve services to this population.

EPSDT care coordination services are available by contacting your local county health department. Please visit our website at www.medicaid.state.al.us and select "General", then select "About". A list of EPSDT care coordinators by county and telephone numbers is available to support your office personnel.

39.11 Program Enhancements

The following enhancements are designed to help the PMP achieve the overall program goal of establishing a medical home for our recipients that is accountable and cost-effective.

39.11.1 Disease Management

Initially patients with a diagnosis of diabetes receiving services through the Alabama Department of Public Health (ADPH) home nursing program will be identified for management. An economically priced biomonitoring box will be placed in the home of patients identified for intervention. This box will be supplied by the University of South Alabama (USA) for a reasonable monthly fee. Peripherals to the box which are not covered through the DME program will also be supplied by USA. USA will bill Medicaid monthly for the "rental" fee on a medical claim form for each recipient utilizing a procedure code and indicating the PMP in the referring provider block. This will allow for necessary tracking and monitoring of the program. An ADPH nurse will perform the home assessment and provide the necessary training to the patients as well as provide necessary follow-up. USA will maintain the database which daily monitors the patient data transmitted via standard telephone lines from the patient's home. Alerts will be generated either to the PMP or the ADPH nurse when a patient

reports outside their specified parameters. The system is very flexible with regard to the structure of an alert protocol. The PMP or the ADPH nurse will follow-up with the patient and determine what services are needed.

In addition to the alert feature the USA system will generate valuable patient data reports monthly for each PMP participating in the biomonitoring program. Summary data will also be provided to Medicaid for monitoring of the program.

Once the program is established statewide additional disease states will be added and the criteria for patient identification will be expanded. Specific codes will be established for use by all parties involved to report services provided. These codes will also allow for tracking and reporting.

39.11.2 Patient Intervention

In addition to the technology that will be available through the biomonitoring box, the Agency will be partnering with the Alabama Department of Public Health to provide patient intervention services. These services will be provided through social workers and will target patients who are identified as non-discriminate users of the emergency room, identified by PMPs as needing educational reinforcement and/or may have a disease state that requires extra monitoring. It is the intention that referrals will be made by the Agency as well as the PMP. These type services will be available statewide and reimbursed fee for service.

39.11.3 InfoSolutions

InfoSolutions is a product offered by Blue Cross/Blue Shield (BC/BS) that will provide the PMP pharmacy information about patients on his panel. Medicaid and BC/BS claims information will be downloaded onto a PDA (personal digital assistant) on a regular basis. This information will then be available to the provider to determine what prescriptions have been prescribed, filled and being taken on a regular basis. Prescribing suggestions will also be available based on Medicaid's Preferred Drug List. This enhancement will help the PMP achieve the Patient 1st goal of reducing pharmacy expenditures. Medicaid is partnering with BC/BS to make this service available to PMPs (and other Medicaid providers) at no cost. BC/BS will be contacting physicians directly to provide more information about InfoSolutions.

39.12 Quality Assurance Activities

Quality assurance activities and program monitoring will be the responsibility of the Medicaid Managed Care Quality Assurance Program and the Patient 1st Program. Monitoring efforts will look at all facets of the program including measuring the PMP against established program goals, determining contract compliance and focusing in on program outcomes all of which involve both administrative and performance measures.

The Profile Report (Profiler) will be the central source of data for program reporting and measurement. This report is based on claims information and one is produced for each PMP. The data in the report is collected from paid claims and is processed to produce characterizations of providers, their enrollee panel and provides comparisons of providers within a peer group.

The Profiler will have three primary components:

- Individual report cards sent to each PMP to provide activity information and program measurements
- A summary report on all providers for use by the Agency. The summary information will be used to monitor the program and identify program outliers.
- Detail reports will identify program areas that need follow-up.

The Agency will also use the Profiler to capture outcome data which, at this time, focuses on the management of Diabetes and Asthma, and the percent of patients with PMP visits as compared to their referral rates to other providers.

Program over-site activities involve monitoring both administrative measures and performance measures.

Administrative measures are collected using focused reviews and are not primarily dependent on paid claims data. These measurements focus on:

- **24/7 Medical Coverage**
Ensures PMPs are meeting the requirement for providing after hours coverage to enrollees.
- **Hospital Admitting Privileges Cost Study**
Demonstrates whether the hospital admission rate and cost associated with PMPs who admit their own patients differ significantly from PMPs who make arrangements for such services through other providers.
- **PMP Patient Disenrollments**
Ensures PMPs are not selectively dismissing patients so that performance measures can be met.
- **EDS Enrollment Process**
Ensures patients are linked to the most appropriate caregiver based on patient choice, family linkage and/or historical patterns of care. This will be aimed at internal processes.
- **Complaints and Grievances**
Ensures patients and providers have a consistent mechanism to express concerns and dissatisfaction with the Patient 1st Program or services provided through the program.
- **Recipient Targeted Survey (REOMBS)**
Monitors the enrollee's health care experience in order to improve the Patient 1st Program and identify potential problems.
- **Outlier Summary Report**
Identifies potential under and over utilization of services.
- **Cost Monitoring**
Costs will be reviewed quarterly to ensure budget neutrality requirements are being met, to track overall costs per recipient and to track costs/savings.

- **Patient PMP Change Rates**

Indicates patients who have changed PMPs more than three (3) times within a six (6) month period. Patients who change PMPs on a frequent basis may be indicative of persons that may benefit from case management services and/or be indicative of problems with the PMP assigned.

Performance measures are primarily claims driven and focus on:

- **EPSDT Screening Rates**

Tracks and monitors EPSDT services. Since this is a preventive measure it is expected to reduce long term health problems in children and provide savings to the Agency.

- **Emergency Room Usage**

Monitors certified and non-certified emergency room utilization.

- **Pharmacy Utilization**

Monitors the use of Medicaid's Preferred Drug List and the use of generic vs. brand name pharmaceuticals.

The Agency must ensure all requirements of the Centers for Medicare and Medicaid Services (CMS) are met; therefore the above list of measures is not inclusive and may be modified.

39.13 Outreach and Education

Outreach and education efforts are coordinated and supported by the Outreach and Education Unit within the Division of Program Support. This unit is responsible for coordinating and disseminating education materials to both providers and recipients, rendering provider visits, and assisting with any other activities that support education efforts.

A PMP may request to schedule an in-service training with the Outreach and Education Unit at any time if the PMP is experiencing billing problems or needs further guidance/training on program procedures and policies in order to ensure that proper Medicaid reimbursement is being made. To request an in-service, the PMP should contact Medicaid's Outreach and Education Program at (334) 353-5203 or fax a request to (334) 353-4193.

39.14 Obtaining Forms / Educational Materials

Patient 1st forms may be obtained by accessing the Medicaid website or by completing an order form (Appendix E, Medicaid Forms) and faxing to (334) 353-4193 or by mailing the form to:

Alabama Medicaid Agency
Outreach and Education Unit
P. O. Box 5624
Montgomery, Alabama 36103-5624

Note: Educational materials are also available for use by providers and may be obtained using the online ordering form on the Agency's website at www.medicaid.state.al.us. A catalog listing these materials is also on the website.

Some materials available for download from the website include:

"Your Guide to Alabama Medicaid". This 36 page booklet describes the services covered, co-payments, the different types of eligibility, patient responsibilities, as well as other useful information.

"Alabama Medicaid Covered Services and Co-Payments" (English or Spanish). Describes services covered by Medicaid and associated co-payments.

"EPSDT Brochure". This is a colorful pamphlet that encourages Well-Child checkups and outlines the periodicity schedule.

"Are you expecting a baby?" This full colored brochure lets pregnant women enrolled in Medicaid know who to contact for prenatal care in their county of residence.

39.14.1 Medicaid Forms

See Appendix E for the following Medicaid Forms:

Attachment One	Immunization Record
Attachment Two	Alabama Medicaid Agency Referral Forms
Attachment Three	EPSDT Documentation
Attachment Four	Complaint/Grievance Form
Attachment Five	PMP Change Form
Attachment Six	Newborn PMP Request Form
Attachment Seven	Request For Educational Material
Attachment Eight	Patient 1 st Override Form
Attachment Nine	Patient 1 st Medical Exemption Form

39.15 Patient 1st Billing Instructions

This section provides billing instructions specific to Patient 1st and EPSDT referred services. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

Patient 1st Referred Services

If you file hard copy claims on the **UB-92**, you must complete the following fields:

Enter referring PMP's nine-digit provider number in block 2

If you file electronically on the UB-92 (**837 Institutional**) using EDS Provider Electronic Solutions software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file hard copy claims on the **CMS -1500**, you must complete the following fields:

Enter the name of the referring Primary Medical Provider (PMP) in block 17.

Enter referring PMP's nine-digit provider number in block 17a.

Enter **"3"** indicating Managed Care in block 24h.

If you file electronically on the **CMS -1500 (837 Professional)** using EDS Provider Electronic Solutions software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

EPSDT and Patient 1st Referred Services

If you file hard copy claims on the **UB-92**, you must complete the following fields:

Enter referring PMP's nine-digit provider number in block 2.

Enter **"A1"** indicating EPSDT referred service in block 24

If you file electronically on the **UB-92 (837 Institutional)** using EDS Provider Electronic Solutions software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file hard copy claims on the **CMS -1500**, you must complete the following fields:

Enter the name of the referring Primary Medical Provider (PMP) in block 17.

Enter referring PMP's nine-digit provider number in block 17a.

Enter **"4"** indicating EPSDT and Managed Care in block 24h.

If you file electronically on the **CMS -1500 (837 Professional)** using EDS Provider Electronic Solutions software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

To bill for a service that requires a Patient 1st referral, the billing provider must have a valid signed referral form in the recipient's medical record. This form should contain the PMP's number to use for billing.

If you have program or policy questions about Patient 1st, contact Medicaid's Medical Services Division's Customer Services at 1-800-362-1504.

39.16 Contact Information Summary

For general Patient 1st billing questions or to request an application package call Provider Assistance: 1-800-688-7989

To increase the maximum number of enrollees within a caseload the request may be faxed to EDS Provider Enrollment: 334-215-4298 or mailed to EDS Provider Enrollment, PO Box 241685, Montgomery, AL 36124

To add counties or disenroll from the program the request may be faxed to EDS Provider Enrollment: 334-215-4298 or mailed to EDS Provider Enrollment, PO Box 241685, Montgomery, AL 36124

To obtain recipient information on eligibility, benefit limits, or coverage call the Provider Communications Unit: 1-800-688-7989

Automated Eligibility Verification Claims Submission (AEVCS): 1-800-727-7848

To address program and policy questions, for individual or specific recipient additions or deletions, for recipient language interpretation services or to report patients enrolled in Patient 1st who should not be enrolled call the Customer Service Unit: 1-800-362-1504

Patient 1st forms requests may be faxed to the Outreach and Education Unit: 334-353-4193

Newborn assignment forms and patient dismissal requests may be faxed to the Patient 1st Program at (334) 353-3856.

For written correspondence to the Agency: Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624